

August 11, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-1481-01

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History:

This female claimant had received prior treatment in 1997 for an exostosis of the right index finger and superficial radial nerve neuritis through June 1998. On September 2, 1999, the patient presented complaining of right arm and shoulder pain due to a fall sustained at work on _____. She was initially treated with oral steroid medication and an injection of the right shoulder. She did respond well to this treatment, but her symptoms recurred.

On 10/14/99, she also complained of worsening right elbow pain. She was diagnosed with ulnar neuritis and lateral epicondylitis. She underwent therapy for her elbow, but her symptoms were exacerbated by this treatment. Neurodiagnostic studies were consistent with ulnar neuropathy across the elbow and median neuropathy across the wrist.

In December 1999, the patient underwent surgery on the right elbow with ulnar nerve release and transposition, followed by rehabilitation. She reportedly made good progress initially following this procedure, but she developed worsening symptoms of lateral epicondylitis of the same elbow.

In May 2000, the patient had surgical treatment for her lateral epicondylitis due to failure of conservative treatment measures. On follow-up visits, she began complaining of wrist pain, right shoulder pain, numbness, and tingling in her hands. The patient was treated with a medrol pack, wrist splints, and ultram for pain.

The patient was then diagnosed with DeQuervain's tenosynovitis; and, on 11/16/00, she underwent another shoulder injection and wrist injection using Celestone. On her return visit in December 2000, the patient continued to have multiple complaints of right arm, elbow, wrist, and shoulder pain. At that time, the patient was given the diagnosis of radial tunnel syndrome with possible reflex sympathetic dystrophy. She was referred to a pain management specialist in January 2001, who treated her with stellate ganglion block. She initially responded well to this treatment, but on subsequent clinic visits, the patient continued to complain of right wrist, arm, and shoulder pain.

Over the following year she underwent numerous evaluations, including evaluation of her cervical spine, and MRI on her shoulder, C-spine, and wrist. She was then diagnosed with a complex regional pain syndrome.

Despite the complexity of this case, treating physicians contend that most of the patient's symptoms are currently originating from the right shoulder. The recommendation has been made to proceed with right shoulder decompression with probable rotator cuff repair/

Disputed Services:

Right shoulder decompression w/rotator cuff repair.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the procedure in question is not medically necessary in this case.

Rationale:

This is a very complex case. The patient has had multiple complaints in her right upper extremity and has been given numerous diagnoses. She had not responded very well to non-operative or surgical treatments performed over the past five years. She had been given multiple steroid injections with minimal relief of her symptoms.

No evidence was provided that the patient has been through an extensive rehab program for improving the range of motion and strength in her right shoulder. Given her diagnoses of complex regional pain syndrome and reflex sympathetic dystrophy, surgery of the right shoulder would be contraindicated due to the potential to aggravate these conditions.

Along with pain management, physical therapy would be the recommended treatment for these pain syndromes. The MRI of the right shoulder was not available for review, but given the available notes, it does not appear that the MRI demonstrated any definitive findings consistent with a rotator cuff tear. An MR arthrogram of the right shoulder may be more conclusive for a tear in this case.

I am the Secretary and General Counsel of ____ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on August 11, 2003.

Sincerely,